SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Filing at a Glance

Company: Sagicor Life Insurance Company

Product Name: Individual Life Insurance Application	SERFF Tr Num: AMFD-128300139	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: 5043	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Francine Cardon	Disposition Date: 04/30/2012
	Date Submitted: 04/25/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 5043	Status of Filing in Domicile: Authorized
Project Number: 5043	Date Approved in Domicile: 04/20/2012
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 04/30/2012
	State Status Changed: 04/30/2012
Deemer Date:	Created By: Francine Cardon
Submitted By: Francine Cardon	Corresponding Filing Tracking Number:

Filing Description:

RE: Sagicor Life Insurance Company
NAIC No.: 60445; FEIN: 74-1915841
Form Nos.: 5043 Individual Life Insurance Juvenile Application
5043-MD Statement to Medical Examiner
5043-PM Paramedical

The above referenced forms are being submitted for your review and approval. No part of this filing contains any unusual or possibly controversial items from normal company or industry standards. These documents are final printed versions. The Application will be used for term life,; whole life, and universal life policies.

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

The Application will be in paper and electronic format. Electronic format means the application may be in an electronic format for policyowner or producer's use instead of paper. If the electronic format is utilized, all required signatures will be verified by assigning a code to the proposed insured/policyowner. If the producer is present, the producer must verify that the person signing is whom they claim to be, by asking for a government issued identification form, such as a passport or a driver's license. If the producer is not present, the signer must insert the code prior to viewing and signing the application.

The Statement to Medical Examiner and the Paramedical will only be utilized by request during the underwriting process.

Please note that we may change the appearance and pagination but not the text of these forms to comply with future changes in print systems. No font will be less than 10 point size. The color and/or weight of the paper may change. No changes to the text other than corrections of typographical errors will be made to the form without re-filing them with you.

Should you have any questions, please contact me toll-free at 480.425.5100 ext. 5652, or via electronic mail at francine_cardon@sagicor.com.

Thank you for your consideration.

Sincerely,

Francine Cardon
State Narrative:

Company and Contact

Filing Contact Information

Francine Cardon, Compliance Analyst	Francine_Cardon@sagicor.com
4343 N. Scottsdale Road	480-425-5100 [Phone]
Suite 300	480-425-5150 [FAX]
Scottsdale, AZ 85251	

Filing Company Information

Sagicor Life Insurance Company	CoCode: 60445	State of Domicile: Texas
4343 N. Scottsdale Road	Group Code: 3766	Company Type:
Suite 300	Group Name:	State ID Number:
Scottsdale, AZ 85251	FEIN Number: 74-1915841	

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

(800) 531-5067 ext. 5653[Phone]

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	Yes
Fee Explanation:	Domicile state filing fee is $100 per application form if filed separately from policy/contract form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sagicor Life Insurance Company	$300.00	04/25/2012	58543878

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/30/2012	04/30/2012

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Disposition

Disposition Date: 04/30/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Individual Life Insurance Application		Yes
Form	Statement to the Medical Examiner		Yes
Form	Paramedical		Yes

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Form Schedule

Lead Form Number: 5043

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	5043	Application/ Enrollment	Individual Life Insurance Application Form	Initial		50.000	5043 filed 4.25.12.pdf
	5043-MD	Application/ Enrollment	Statement to the Medical Examiner Form	Initial		50.000	5043-MD 4.25.12.pdf
	5043-PM	Application/ Enrollment	Paramedical Form	Initial		50.000	5043-PM 4.25.12.pdf

Sagicor
LIFE INSURANCE COMPANY

INDIVIDUAL LIFE INSURANCE APPLICATION

LIFE INSURANCE APPLICATION - PART 1

SECTION 1 – Proposed Insured Information

Name: _____ Sex: ☐ Male ☐ Female
(First) (MI) (Last)

Street Address: _____
City State Zip Code

Former Address: _____
(If at current address less than 2 years) City State Zip Code

Date of Birth: _____ Place of Birth: _____ Marital Status: _____

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID: Type/State: _____ Number: _____

Employer's Name: _____ Occupation: _____ Annual Earned Income: $ _____

Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete a Foreign Travel & Residence Questionnaire and provide an Alien Registration Number.)*

SECTION 2 – Proposed Owner Information *(Complete if Owner different than Proposed Insured)*

☐ **Check if Proposed Owner is not an Individual** *(If this is a Trust, please provide a copy of the Title & Signature page)*

Name: _____ Date of Birth: _____
(First) (MI) (Last)

Street Address: _____
City State Zip Code

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID: Type/State: _____ Number: _____

Is the Proposed Owner a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, provide an Alien Registration Number.)*

1. Does the Proposed Owner have one of the following relationships with the Proposed Insured: Spouse, Child, Parent, Grandchild, Grandparent, Brother, or Sister? ☐ Yes ☐ No If "Yes", Relationship: _____
2. If "No" to the above question, is the Proposed Insured a legal dependent, under Federal tax law, of the Proposed Owner or is the Proposed Owner the legal guardian of the Proposed Insured? ☐ Yes ☐ No
3. If "No" to the above questions, does the Proposed Owner have a lawful and material economic interest in having the life of the Proposed Insured continue? ☐ Yes ☐ No

SECTION 3 – Beneficiary Information *(If there are Additional Beneficiaries, attach information on a separate sheet of paper.)*

☐ **Check if Beneficiary is not an Individual**

Primary Beneficiary Name: _____ Relationship: _____

Street Address: _____
City State ZIP Code

Social Security Number: _____ Date of Birth: _____

Is the Primary Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please complete provide an Alien Registration Number.)*

SECTION 3 – Beneficiary Information *(continued)*

☐ **Check if Contingent Beneficiary is not an Individual**

Contingent Beneficiary Name: _____ Relationship: _____

Street Address: _____

City *State* *Zip Code*

Social Security Number: _____ Date of Birth: _____

Is the Contingent Beneficiary a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please provide an Alien Registration Number.)*

SECTION 4 – Payor Information *(Complete if Payor different than Proposed Insured or Owner)*

☐ **Check if Payor is not an Individual** *(If this is a Trust, please provide a copy of the Title & Signature page)*

Name: _____ Date of Birth: _____

(First) *(MI)* *(Last)*

Street Address: _____

City *State* *Zip Code*

Social Security Number: _____ E-Mail Address: _____

Telephone No: Home: _____ Other: _____

Government Issued Picture ID: Type/State: _____ Number: _____

Is the Payor a U.S. Citizen? ☐ Yes ☐ No Alien Registration Number: _____

*(If **NO**, please provide an Alien Registration Number.)*

If the Payor will also be a beneficiary on the Policy, the following questions must be answered:

1. Does the Proposed Payor have one of the following relationships with the Proposed Insured: Spouse, Child, Parent, Grandchild, Grandparent, Brother, or Sister? ☐ Yes ☐ No If "Yes", Relationship: _____
2. If "No" to the above question, is the Proposed Insured a legal dependent, under Federal tax law, of the Proposed Payor or is the Proposed Payor the legal guardian of the Proposed Insured? ☐ Yes ☐ No
3. If "No" to the above questions, does the Proposed Payor have a lawful and material economic interest in having the life of the Proposed Insured continue? ☐ Yes ☐ No

SECTION 5 – Coverage Selection

Plan: _____ Face Amount Applied For: $ _____

☐ Tobacco Rates ☐ Non-Tobacco Rates

[☐ Accidental Death Benefit] [☐ Waiver of Premium]

[☐ Waiver of Monthly Deductions (Universal Life)]

Universal Life Elections (select one for each)

Guideline Premium Test ☐ **OR** Cash Value Accumulation Test ☐

Death Benefit Option ☐ A **OR** ☐ B

[Automatic Premium Loan Option (select one) ☐ Yes ☐ No (Whole Life Only)]

Do you intend to finance the premium for this policy? ☐ Yes ☐ No *(If yes, Company will not issue policy)*

Premium Class Quoted: _____ (Policy will be issued in the premium class quoted unless advised otherwise.)

Premium Collected with Application: $ _____ Transfer/1035 Exchange: ☐ Yes ☐ No Amount: $ _____

Planned Modal Premium: $ _____ Draft Initial Premium: ☐ Yes ☐ No

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT (*Complete an Electronic Funds Transfer (EFT) Authorization)*

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into an agreement to sell, transfer, or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

SECTION 6 – In Force/Replacement Information (if *Yes* to any question, list information below)

1. Will any life insurance or annuity in this or any other company be replaced or changed as a result of this application? *(If **YES**, please complete a Replacement Form.)* ☐ Yes ☐ No
2. Does the Proposed Insured:
   a) Have any other life insurance or annuity in force? ☐ Yes ☐ No
   b) Have any application (including reinstatement) for life insurance or annuity now pending? ☐ Yes ☐ No
3. Has the Proposed Insured applied for any life insurance or annuity in the last ninety (90) days? ☐ Yes ☐ No

Proposed Insured	Company	Policy #	Amount	Issue Date	Plan Type

SECTION 7 – Initial Medical and Personal History Questions

	Proposed Insured
1. In the past 24 months have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or gum?	☐ Yes ☐ No
2. In the past 24 months have you piloted an aircraft, or do you have any intensions of flying in the future, other than as a passenger on commercial airlines? (*If **YES**, please complete an Aviation Questionnaire.)*	☐ Yes ☐ No
3. In the past 24 months have you participated in or in the next 24 months do you intend to participate in: aerial sport, auto racing, ballooning, hang gliding, motorcycle racing, motor sport, mountain climbing, rock climbing, rodeo, underwater diving? (*If **YES**, please complete an Avocation Questionnaire.)*	☐ Yes ☐ No
4. In the past 24 months have you had your Driver's License revoked or suspended, or been convicted of any moving violations, or for driving while intoxicated or under the influence of alcohol and/or drugs?	☐ Yes ☐ No
5. In the next 2 years do you intend to travel outside the United States for more than a three week period for personal reason or on vacation? *(If **YES**, please complete a Foreign Travel & Residence Questionnaire.)*	☐ Yes ☐ No
6. In the past 5 years have you been convicted of or are you awaiting trial for a felony?	☐ Yes ☐ No
7. In the past 5 years have you had an application for insurance or reinstatement of insurance declined, postponed, rated or otherwise modified?	☐ Yes ☐ No

8. Please provide details of your family history in the section below:

Family Member	Living?	Cause of Death?	Age of Death?
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Sister(s)	☐ Yes ☐ No ☐ N/A		
Brother(s)	☐ Yes ☐ No ☐ N/A		

SECTION 8 – Additional Information/Special Request or Instructions

LIFE INSURANCE APPLICATION - PART 2

SECTION 9 -– Additional Medical and Personal History Questions

(Record details to "Yes" answer in Section 9B below)

Proposed Insured

1. Please provide the name of the physician you consult for routine care or illness, including the names of any medical professional(s) consulted in the last 5 years.

Physician's Name	Physician's Address	Date & Reason for Consultation or Treatment

2. Have you been treated in or confined to a Hospital, Psychiatric, Extended or Assisted Care or Nursing Facility in the past 5 years? ☐ Yes ☐ No

3. Please provide your Current Height _____ Weight _____ lbs.

   a) Have you experienced any weight loss or weight gain in the past 12 months (except for pregnancy)? ☐ Yes ☐ No

4. In the past 12 months have you been advised by a physician to be hospitalized or to have diagnostic tests, excluding tests related to the Human Immunodeficiency Virus (AIDS virus), or surgery, or any medical procedure that has not been completed or for which the results are not yet available? ☐ Yes ☐ No

5. Are you presently taking any medications prescribed by a physician, hospital or other medical professional? ☐ Yes ☐ No

6. Are you currently disabled and/or receiving disability benefits? ☐ Yes ☐ No

7. Have you ever tested positive for the HIV virus or been diagnosed by a member of the medical profession as having AIDS or the AIDS Related Complex (ARC)? ☐ Yes ☐ No

8. In the past 10 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

   a) Cancer, tumor, cyst, melanoma or any other malignant growth? ☐ Yes ☐ No

   b) Chest pains, angina, heart attack or heart failure, irregular heartbeat or any other coronary artery disease or disorder? ☐ Yes ☐ No

   c) High blood pressure (Hypertension), stroke, transient ischemic attach (TIA), or other blood vessel disease or disorder? ☐ Yes ☐ No

   d) Diabetes and/or high or low blood sugar? ☐ Yes ☐ No

   e) Kidney stones, sugar, albumin or blood in the urine, or any other disease or disorder of the kidneys, bladder, urinary or reproductive system? ☐ Yes ☐ No

9. In the past 5 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

   a) Asthma, emphysema, chronic lung or other disease of the respiratory system? ☐ Yes ☐ No

   b) Epilepsy, seizures, convulsions, fainting or memory disorder? ☐ Yes ☐ No

   c) The use of alcohol and drugs and have been advised to discontinue or decrease the use of alcohol and/or the use of prescribed or non-prescribed drugs or other medications? ☐ Yes ☐ No

   d) Depression, anxiety, mental or emotional disorder, or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No

   e) Ulcers, colitis, hepatitis, or any other disease or disorder of the liver, pancreas, stomach or intestines? ☐ Yes ☐ No

   f) Arthritis, gout, disease or disorder of the spine, bones, joints, or muscles? ☐ Yes ☐ No

SECTION 9B – Details To All "Yes" Answers Above:

SECTION 10 – Fraud Warning

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SECTION 11 – Authorization and Acknowledgement

I understand that I am applying for life insurance coverage issued by Sagicor Life Insurance Company ("Sagicor"). I understand and consent that this application, and information obtained pursuant to this authorization may be used by Sagicor to evaluate my eligibility for life insurance.

I authorize the release to Sagicor of all information requested about me. This information may be released to Sagicor's authorized representatives. Authorized representatives include any consumer reporting agency acting on their behalf. Each of the following may be a source of information: the Medical Information Bureau, Inc. ("MIB"); my employer; physician, medical practitioner, hospital, clinic, or medically related facility; insurance or reinsuring company; consumer reporting agency; any other organization or insurance support organization; and a Pharmacy Benefit Manager.

Information means facts about me. Those facts include, but are not limited to; information about mental or physical health; other insurance coverage; use of drugs or alcohol; motor vehicle records; avocations; employment; prescription drug records; hazardous activities; character; general reputation; mode of living; finances; vocation; and other personal traits.

I understand and agree that Sagicor may disclose all or some of my information to its insurance administrators, its reinsurance companies, the producer who solicited my application and his or her principals, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 30 months. I understand that I or my authorized representative may receive a copy of the authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by sending written notice to Sagicor's home office. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my right to revoke this authorization is limited to the extent that Sagicor has not already taken action in reliance on the authorization.

To the best of my knowledge and belief, the statements and answers given on this application are true, complete, and correctly recorded. I understand that a policy does not go into effect and no liability exists for Sagicor until the policy is delivered and accepted by the Owner, the first full premium is paid, there has been no change in the health of the Proposed Insured that would change any of the answers in this application, and Sagicor has received an executed copy of both Part 1 and Part 2 of this application. I understand and agree that no producer may accept risks or pass upon insurability, make or modify contracts, or waive any of Sagicor's rights or requirements. I have received a copy of the "Disclosure Notice to Proposed Insured", and when applicable, the "Accelerated Benefit Insurance Rider Disclosure Statement".

To help the government fight the funding for terrorism and money laundering activities, federal law requires all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means for you: when you apply for life insurance, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We will also ask to see your driver's license or other government issued photo identification. If you wish to have more detailed explanation of our information practices, please write to: Sagicor Life Insurance Company; Attention: Client Service Department; PO Box 52121; Phoenix, AZ 85072-2121.

Under the penalties of perjury, by my signature on this application, I certify that: (1) the Social Security number shown on this application is my correct taxpayer identification number and, (2) I am not subject to back-up withholding either because I have not been notified by the IRS that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the IRS has notified me that I am no longer subject to back-up withholding.

Signed: _____ Date Signed: _____

City State

_____ _____

Proposed Insured Signature
(If a minor, signature of parent or guardian)

Proposed Owner's Signature
(if other than Proposed Insured)

_____ _____

Writing Producer's Signature

Writing Producer's Name/Number *(Please Print)*

SECTION 12 – This section should be completed by the Producer.
For questions about this application or requirements, contact our Underwriting Department.

Producer Name (Please Print)	Producer ID Number	% Split

Each licensed Producer will share equally unless otherwise indicated.

1. Have you delivered the consumer protection notices to the Proposed Owner and Proposed Insured? ☐ Yes ☐ No
2. Did you personally meet with the Proposed Owner and Proposed Insured, obtain their Social Security Number(s) and view for each a Government issued photo ID? *(If **YES**, specify the type of ID and ID number. If **NO**, please explain why.)* _____ ☐ Yes ☐ No
3. If premium was accepted, was the Conditional Receipt completed and delivered to the Proposed Owner? ☐ Yes ☐ No
4. Does the Proposed Insured have any other life insurance or annuities currently in force or pending reinstatement? ☐ Yes ☐ No
5. Will any annuity or life insurance presently in force be replaced or changed by this policy that is being applied for? *(If **YES**, and if required by state regulation, any Replacement Comparison, Notice, or Statement must accompany this application.)* ☐ Yes ☐ No
6. Is this a 1035 Exchange? *(If **YES**, attach all required forms.)* ☐ Internal ☐ External ☐ Yes ☐ No
7. Is this a premium finance case? *(If yes, Company will not issue policy)* ☐ Yes ☐ No
8. How long have you known the Proposed Owner? _____ Proposed Insured? _____
9. Are you related to the Proposed Owner? ☐ Yes ☐ No Proposed Insured? ☐ Yes ☐ No
   If **YES**, how are you related? _____
10. Does the Proposed Owner understand and speak English? ☐ Yes ☐ No Proposed Insured? ☐ Yes ☐ No
    If **NO**, please explain: _____
11. Was any other person present to answer questions? ☐ Yes ☐ No
    If **YES**, who was present and why? _____
12. What is the purpose of this insurance purchase? _____
13. Do you know of anything not disclosed in this application that may affect the risk of this life insurance purchase?
    ☐ Yes ☐ No If **YES**, please explain: _____
14. Remarks: _____

Producer's Certification

I certify that I saw and know the Proposed Owner and Proposed Insured to be the person(s) described in this application, and have reviewed the appropriate documentation, and have truly and accurately recorded the information supplied by the Proposed Owner and Proposed Insured, that I know of no condition affecting the insurability of the applicant not fully set forth in the application, and that I have made no declaration, representation, or waiver regarding coverage or the provisions or terms of the application or policy. I further certify that I am licensed in the state in which this application was completed and have delivered all required notices and disclosures and fully complied with all privacy and replacement regulations. I also assume full responsibility for the delivery of the policy and the submission of the first premium.

Signed (Writing Producer): _____ Date Signed: _____

Phone Number: _____ Fax Number: _____ E-mail Address: _____

Sagicor

LIFE INSURANCE COMPANY

Disclosure Notice to Proposed Insured

Leave with the Proposed Insured

Investigative Consumer Report Notice

You are our most important source of information, but personal information may also be collected from other sources. Such information may, in certain circumstances, be disclosed to third parties without your authorization.

An investigative consumer report may be prepared in which information is obtained from public records and through personal interviews with: your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed as part of the report. Upon written request to Sagicor, further information on the nature and scope of the report will be provided.

Information Practices

Personal information we obtain during the underwriting process is private and confidential. We will not disclose such information to other persons or organizations without your written authorization, except to the extent necessary to conduct our business, as permitted by law, or as required by law. You have the right to be told about and obtain access to certain items or personal information in our files. You also have the right to request correction of information you believe to be inaccurate. If you would like to receive a more detailed explanation of our information practices, please write to:

Sagicor Life Insurance Company
Attention: Client Service Department
P.O. Box 52121
Phoenix, AZ 85072-2121

Medical Information Bureau (MIB) Notice

Information regarding your insurability will be treated as confidential. Sagicor or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB). The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life insurance or health insurance coverage, or a claim for benefit is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. MIB's toll free number is 866-692-6901 or TTY 866-346-3642. Website www.mib.com.

Sagicor Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Sagicor

LIFE INSURANCE COMPANY

Conditional Receipt ("Receipt")

Detach and leave this page with the Proposed Owner if premium is submitted with the application. No payment may be accepted with the application, if, within the past three (3) years, any Proposed Insured has been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession concerning heart disease, stroke, cancer, HIV or AIDS.

Make all checks payable to: **Sagicor Life Insurance Company**.
Do not make checks payable to the producer or leave the payee blank.
Do not pay with cash.

Received from _____ as the Proposed Owner, the sum of $ _____, for the insurance application

dated _____, with _____ as the Proposed Insured.

The policy you applied for will not become effective unless and until a policy is delivered to you, and all other conditions of coverage are met. Conditional insurance under the terms of the policy applied for may become effective as of the date the Proposed Insured completes in its entirety the tele-interview process to answer the questions in Part 2 of the application (the "Effective Date"). Such conditional insurance is subject to the conditions and limitations of this Receipt. Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. The Proposed Insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with Sagicor's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all of the Proposed Insured's statements and answers given in Part 1 of the application and during the tele-interview process for Part 2 of the application are true;
3. The payment accompanying the application is not less than the full initial premium for the mode of payment chosen in the application and is received at Sagicor's Home Office within the lifetime of the Proposed Insured; and
4. The following items have been signed and received at Sagicor's Home Office: Part 1 of the application; and any required supplemental application, questionnaire(s), addendum, and/or amendment to the application.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt(s) issued by Sagicor shall be limited to the lesser of the amount(s) applied for or [$250,000] of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

There will be no conditional insurance coverage and the Company's liability will be limited to returning any premium submitted to the Company with this Receipt if any of the following occurs: (a) the Proposed Insured does not complete in its entirety the tele-interview process; (b) one or more of the Receipt's conditions have not been met exactly; (c) the Proposed Insured dies by suicide; or (d) the Company does not approve and accept the application for insurance within ninety (90) days of the date the Proposed Insured completes in its entirety the tele-interview process, thus deeming the application rejected by the Company.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) ninety (90) days from the date the Proposed Insured completes in its entirety the tele-interview process; (b) the date Sagicor either mails a notice to the Proposed Owner rejecting the application and/or mails a refund of any amount paid with the application; (c) the date the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date Sagicor offers to provide insurance on terms that differ from the insurance for which you have applied.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by the producer. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at _____ on _____ _____

City *State* *Date* *Producer's Signature*

Sagicor
LIFE INSURANCE COMPANY

4343 N. Scottsdale Rd #300
Scottsdale, AZ 85251
T (888) 724-4267
F (480) 425-5150

STATEMENT TO THE MEDICAL EXAMINER

IN CONTINUATION OF AND FORMING A PART OF MY APPLICATION FOR INSURANCE

USE BLACK INK ONLY

PART THREE This Examination must be made in private and answers inserted in Examiner's own HANDWRITING.

Name of Proposed Insured: _____ Date of Birth: _____

Proposed Insured's Sex: ☐ Male ☐ Female Name of Producer: _____

Examination made in private at: ☐ Examiner's Office ☐ Proposed Insured's Home ☐ Proposed Insured's Office ☐ A.M. ☐ P.M.

MEDICAL HISTORY (to be recorded by the medical examiner)	**YES**	**NO**	
1. Please provide the name of the physician you consult for routine care or illness, including the names of any medical professional(s) consulted in the last 5 years.			**Please provide details and Name, Address, Phone Number of all Doctors, listing the Physician having the most complete Medical Records first.**
2. Have you been treated in or confined to a Hospital, Psychiatric, Extended or Assisted Care or Nursing Facility in the past 5 years?	☐	☐	
3. Have you experienced any weight loss or weight gain in the past 12 months (except for pregnancy)?	☐	☐	
4. In the past 12 months have you been advised by a physician to be hospitalized or to have diagnostic tests, excluding tests related to the Human Immunodeficiency Virus (AIDS virus), or surgery, or any medical procedure that has not been completed or for which the results are not yet available?	☐	☐	
5. Are you presently taking any medications prescribed by a physician, hospital or other medical professional?			
6. Are you currently disabled and/or receiving disability benefits?	☐	☐	
7. Have you ever tested positive for the HIV virus or been diagnosed by a member of the medical profession as having AIDS or the AIDS Related Complex (ARC)?	☐	☐	
8. In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:			
a) Cancer, tumor, cyst, melanoma or any other malignant growth?	☐	☐	
b) Chest pains, angina, heart attack or heart failure, irregular heartbeat or any other coronary artery disease or disorder?	☐	☐	
c) High blood pressure (Hypertension), stroke, transient ischemic attach (TIA), or other blood vessel disease or disorder?	☐	☐	
d) Diabetes and/or high blood sugar?	☐	☐	
e) Kidney stones, sugar, albumin or blood in the urine, or any other disease or disorder of the kidneys, bladder, urinary or reproductive system?	☐	☐	
9. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:			
a) Asthma, emphysema, chronic lung or other disease of the respiratory system?	☐	☐	
b) Epilepsy, seizures, convulsions, fainting or memory disorder?	☐	☐	
c) The use of alcohol and drugs and have been advised to discontinue or decrease the use of alcohol and/or the use of prescribed or non-prescribed drugs or other medications?	☐	☐	
d) Depression, anxiety, mental or emotional disorder, or any other disease or disorder of the brain or nervous system?	☐	☐	
e) Ulcers, colitis, hepatitis, or any other disease or disorder of the liver, pancreas, stomach or intestines?	☐	☐	
f) Arthritis, gout, disease or disorder of the spine, bones, joints, or muscles?	☐	☐	

The Date & Reason for your Last Doctor Visit:

I understand that I am applying for life insurance coverage from Sagicor Life Insurance Company, and that any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I represent, to the best of my knowledge and belief, that all the above statements and answers are true, complete and correctly recorded. I agree that they will form a part of my application for life insurance and become a part of any contract of insurance issued as a result of that application.

Medical Examiner	Proposed Insured	Date

MEDICAL EXAMINER'S REPORT

PART FOUR

THIS REPORT IS CONFIDENTIAL BETWEEN COMPANY AND EXAMINER **TO BE COMPLETED IN PRIVATE**

Examination of heart and lungs must be with stethoscope against bared skin **BY EXAMINER ONLY.**

EXAMINATION OF: **PLEASE GIVE FULL DETAIL OF ADVERSE**
(Print full name) **FINDINGS IN "DETAILS" SPACE BELOW**

10. A. HEIGHT (in shoes) C. GIRTH (males only) in inches
_____ ft _____ in Chest at forced expiration _____
Exact Scale Chest at forced inspiration _____
B. WEIGHT (in clothes) Abdomen fully relaxed _____
pounds

11. BLOOD PRESSURE: All readings to be taken in sitting position. If first reading is 140/90 or over make two additional observations at intervals. Record all readings.

	Systolic	Diastolic (fifth phase)
1st reading		
2nd reading		
3rd reading		

12. Temperature 17. Pulse Rate **IF PULSE IS IRREGULAR, complete exercise test**

19. Urinalysis

	Specific Gravity	Albumin	Sugar
(To be completed by examiner In all cases)			

	Y	N
a.) Are you satisfied specimen is authentic?	☐	☐
b.) Are you forwarding specimen to Administrative Office?	☐	☐

NOTE:
Specimen should be sent to Administrative Office with each examination.

20. Have you any pertinent information affecting proposed insured not brought out above? ☐ ☐

On inquiry and examination is there evidence of:

DETAILS

		YES	NO
13.	Present of past disease or abnormalities of:		
a)	Brain, nervous system? (test reflexes; coordination)	☐	☐
b)	Eye, ears, nose, throat, teeth, gums?	☐	☐
c)	Thyroid, lymph glands or endocrine system?	☐	☐
d)	Lungs or respiratory system?	☐	☐
e)	Abdominal organs or digestive tract?	☐	☐
f)	Genito-urinary organs?	☐	☐
g)	Skin, skeletal structure or muscular system?	☐	☐
14.	Hernia? (If yes, describe.)	☐	☐
15.	Varicose veins or ulcers?	☐	☐
16.	Arteriosclerosis; other peripheral vascular disease?	☐	☐
17.	Present or past disease or abnormalities of heart of blood vessels?	☐	☐
18. a)	Is there a history of rheumatic fever, scarlet fever, endocarditis, recurrent tonsillitis?	☐	☐
b)	Is there hypertrophy? (If yes, state degree.)	☐	☐
c)	Is there a murmur?	☐	☐

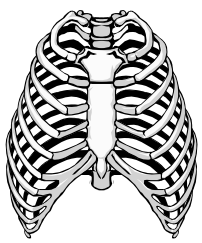
Type:	Quality:	Intensity:	Location:
☐ Systolic	☐ Blowing	☐ Faint	☐ Apical
☐ Diastolic	☐ Rough	☐ Moderate	☐ Pulmonic
☐ Presystolic	☐ Musical	☐ Loud	☐ Aortic

d)	Is murmur constant?	☐ ☐
e)	Is murmur transmitted?	☐ ☐
	If yes, where? _____	

EXERCISE TEST 50 vigorous hops	Pulse Rate	Irregularities No. per Min	Murmur Present	Murmur Absent
BEFORE EXERCISE				
IMMEDIATELY AFTER				
3 MINUTES AFTER				

PLEASE RECORD FINDINGS USING FOLLOWING SYMBOLS:
Position of apex beat (_____ ins or _____ cms from midsternum in _____ iInterspace)
Murmur:
Area of distribution ☐
Point of greatest intensity ○
Direction of transmission →

Midsternum **Midclavicle**



Signature of Medical Examiner **Address** **Date**

5043-MD

Sagicor
LIFE INSURANCE COMPANY

4343 N. Scottsdale Rd #300
Scottsdale, AZ 85251
T (888) 724-4267
F (480) 425-5150

PARAMEDICAL

IN CONTINUATION OF AND FORMING A PART OF MY APPLICATION FOR INSURANCE

USE BLACK INK ONLY

PART THREE This Examination must be made in private and answers inserted in Examiner's own HANDWRITING.

Name of Proposed Insured: _____ Date of Birth: _____

Proposed Insured's Sex: ☐ Male ☐ Female Name of Producer: _____

Examination made in private at: ☐ Examiner's Office ☐ Proposed Insured's Home ☐ Proposed Insured's Office ☐ A.M. ☐ P.M.

MEDICAL HISTORY (to be recorded by the medical examiner)	**YES**	**NO**
1. Please provide the name of the physician you consult for routine care or illness, including the names of any medical professional(s) consulted in the last 5 years.		
2. Have you been treated in or confined to a Hospital, Psychiatric, Extended or Assisted Care or Nursing Facility in the past 5 years?	☐	☐
3. Have you experienced any weight loss or weight gain in the past 12 months (except for pregnancy)?	☐	☐
4. In the past 12 months have you been advised by a physician to be hospitalized or to have diagnostic tests, excluding tests related to the Human Immunodeficiency Virus (AIDS virus), or surgery, or any medical procedure that has not been completed or for which the results are not yet available?	☐	☐
5. Are you presently taking any medications prescribed by a physician, hospital or other medical professional?		
6. Are you currently disabled and/or receiving disability benefits?	☐	☐
7. Have you ever tested positive for the HIV virus or been diagnosed by a member of the medical profession as having AIDS or the AIDS Related Complex (ARC)?	☐	☐
8. In the past 10 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:		
a) Cancer, tumor, cyst, melanoma or any other malignant growth?	☐	☐
b) Chest pains, angina, heart attack or heart failure, irregular heartbeat or any other coronary artery disease or disorder?	☐	☐
c) High blood pressure (Hypertension), stroke, transient ischemic attach (TIA), or other blood vessel disease or disorder?	☐	☐
d) Diabetes and/or high blood sugar?	☐	☐
e) Kidney stones, sugar, albumin or blood in the urine, or any other disease or disorder of the kidneys, bladder, urinary or reproductive system?	☐	☐
9. In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:		
a) Asthma, emphysema, chronic lung or other disease of the respiratory system?	☐	☐
b) Epilepsy, seizures, convulsions, fainting or memory disorder?	☐	☐
c) The use of alcohol and drugs and have been advised to discontinue or decrease the use of alcohol and/or the use of prescribed or non-prescribed drugs or other medications?	☐	☐
d) Depression, anxiety, mental or emotional disorder, or any other disease or disorder of the brain or nervous system?	☐	☐
e) Ulcers, colitis, hepatitis, or any other disease or disorder of the liver, pancreas, stomach or intestines?	☐	☐
f) Arthritis, gout, disease or disorder of the spine, bones, joints, or muscles?	☐	☐

Please provide details and Name, Address, Phone Number of all Doctors, listing the Physician having the most complete Medical Records first.

The Date & Reason for your Last Doctor Visit:

I understand that I am applying for life insurance coverage from Sagicor Life Insurance Company, and that any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I represent, to the best of my knowledge and belief, that all the above statements and answers are true, complete and correctly recorded. I agree that they will form a part of my application for life insurance and become a part of any contract of insurance issued as a result of that application.

Medical Examiner	Proposed Insured	Date

PARAMEDICAL REPORT

PART FOUR

THIS REPORT IS CONFIDENTIAL BETWEEN COMPANY AND EXAMINER **TO BE COMPLETED IN PRIVATE**

Examination of heart and lungs must be with stethoscope against bared skin **BY EXAMINER ONLY.**

EXAMINATION OF:	**PLEASE GIVE FULL DETAIL OF ADVERSE**
(Print full name)	**FINDINGS IN "DETAILS" SPACE BELOW**

10. a) HEIGHT (in shoes) _____ feet _____ inches 10. b) WEIGHT (in clothes) _____ pounds

10. c) GIRTH (males only) in inches Chest at forced expiration _____ Chest at forced inspiration _____ Abdomen fully relaxed _____

11. BLOOD PRESSURE: All readings to be taken in the sitting position. If first reading is 140/90 or over, make two additional observations At intervals. Record all readings.

	First Reading	Second Reading	Third Reading
Systolic			
Diastolic (5th phase)			

12. Temperature _____ 13. Pulse Rate _____

14. Urinalysis **(To be completed by examiner in all cases)**

	YES	NO
a) Are you satisfied that the specimen is authentic?	☐	☐
b) Are you forwarding the specimen to the Administrative Office?	☐	☐

Specific Gravity	Albumin	Sugar

NOTE: Specimen should be sent to the Administrative Office with each examination.

	YES	NO
15. Do you have any pertinent information affecting the proposed insured that was not brought out above?	☐	☐

GIVE DETAILS

Signature of Medical Examiner **Address** **Date**

SERFF Tracking Number:	*AMFD-128300139*	*State:*	*Arkansas*
Filing Company:	*Sagicor Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*5043*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Individual Life Insurance Application*		
Project Name/Number:	*5043/5043*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
5043 Read Cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Not applicable to this filing. Please refer to the Forms Schedule tab.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
5043 SOV 4.25.12.pdf

READABILITY CERTIFICATION

To Whom It May Concern:

This is to certify that the attached forms achieved a Flesch Reading Ease Score and are in compliance with applicable laws and regulations as follows:

Form #	Title	Flesch Score
5043	Individual Life Insurance Application	50.0
5043-MD	Statement to the Medical Examiner	
5043-PM	Paramedical	

Sagicor Life Insurance Company

Name: James Golembiewski
Title: VP Compliance & Associate General Counsel

April 25, 2012
Date

STATEMENT OF VARIABILITY

INDIVIDUAL LIFE INSURANCE APPLICATION

FORM # 5043

Page 2 – Section 5 – Coverage Selection

Riders Listed	Riders' names or availability may change
Automatic Premium Loan Option (select one)	Additional products may be listed if the of option is added to other types of insurance. No other types of insurance would be listed without review and approval of the product.

Page 8 – Conditional Receipt ("Receipt")

8th paragraph	Dollar amount limit on coverage may change.